

Pre-Waitlist Transplant Evaluation Form Instructions

OPTN Patient Identification

Transplant Center: The transplant center information displays. Verify that the center information is the hospital where the patient is being evaluated.

Transplant Center Code: The transplant center information displays. Verify that the center information is the hospital where the patient is being evaluated.

Patient MRN: Enter the patient's Medical Record Number at the Transplant Center. This is a **required** field.

Organ: Select the organ evaluated for transplantation. This is a **required** field.

Must select one:

Heart
Heart-Lung
Intestine
Kidney
Kidney-Pancreas
Liver
Lung
Pancreas
Pancreas Islets
VCA - abdominal wall
VCA - external male genitalia
VCA - head and neck
VCA - lower limb
VCA - musculoskeletal composite graft segment
VCA - other genitourinary organ
VCA - spleen
VCA - upper limb
VCA - uterus
VCA - vascularized gland

Patient Demographics

First Name: Enter the patient's first name. This is a **required** field.

Middle Name: Enter the patient's middle name. This is a **required** field.

Must either:

Provide value,

Select unknown, or

Select not applicable.

Last Name: Enter the patient's last name. This is a **required** field.

DOB: Enter the patient's date of birth. This is a **required** field.

Birth Sex: Select the patient's sex (Male or Female), based on biologic and physiologic traits at birth. This is a **required** field.

Must select one:

Female

Male

SSN: Enter the patient's social security number. This is a **required** field.

Must either:

Provide value,

Select unknown, or

Select not applicable.

Race: OMB defines race as a person's self-identification with one or more social groups. This is a **required** field.

Must select at least one:

White

European Descent

Arab or Middle Eastern

North African (non-Black)

Other Origin

Origin Not Reported

Black or African American

African American

African (Continental)

West Indian

Haitian

Other Origin

Origin Not Reported

Asian

Asian Indian/Indian Sub-Continent

Chinese

Filipino

Japanese

Korean

Vietnamese

Other Origin

Origin Not Reported

American Indian or Alaska Native

American Indian

Eskimo

Aleutian

Alaska Indian

Other Origin

Origin Not Reported

Native Hawaiian or Other Pacific Islander

Native Hawaiian

Guamanian or Chamorro

Samoan

Other Origin

Origin Not Reported

Race Not Reported

Ethnicity: OMB defines ethnicity to be whether or not a person self-identifies as Hispanic or Latino. This is a **required** field.

Must select one:

- Hispanic or Latino,
- Not Hispanic or Latino, or
- Ethnicity not reported.

Contact Information

Primary Phone Number: Enter the primary phone number at the time of evaluation. This is a **required** field.

Must either:

- Provide value (000-000-0000),
- Select unknown, or
- Select not applicable.

Permanent Street Address: Enter the street address where the patient permanently resides at the time of evaluation (location of full-time residence, not where the patient is currently staying for the evaluation). This is a **required** field.

Must either:

- Provide value or
- Select unknown.

City of Permanent Residence: Enter the city where the patient permanently resides at the time of evaluation (location of full-time residence, not where the patient is currently staying for the evaluation) This is a **required** field.

Must either:

- Provide value or
- Select unknown.

State of Permanent Residence: Select the name of the state of the patient's permanent address at the time of evaluation (location of full-time residence, not where the patient is currently staying for the evaluation). This is a **required** field.

Must either:

- Provide value or
- Select unknown.

Zip Code of Permanent Residence: Enter the patient's zip code at the time of evaluation (location of full-time residence, not where the patient is currently staying for the evaluation). This is a **required** field.

Must either:

Provide value or

Select unknown.

Country of Permanent Residence: Enter the country where the patient permanently resides at the time of evaluation (location of full-time residence, not where the patient is currently staying for the evaluation). This is a **required** field.

Financial Resources

Source of Payment/Primary: Select the patient's primary source of payment (largest contributor) during the evaluation period. This is a **required** field.

Must select one:

- Private insurance (Commercial Health Insurance)
- Public insurance – Medicaid
- Public insurance – Medicare FFS (Fee-for-Service)
- Public insurance – Medicare Part C or Medicare Advantage
- Public insurance – CHIP (Children's Health Insurance Program)
- Public insurance – Department of VA
- Public insurance – TRICARE
- Public insurance – Indian Health Service
- Public insurance – State program
- Self-pay
- Donation
- Free Care (Charity Care)
- Pending
- Foreign Government

Source of Payment/Secondary: Select the patient's secondary source of payment during the evaluation period. This is a **required** field.

Must select one:

TBD

Working for Income: Required for patients 18 years or older, If the patient is employed (full time or part time) and receiving income at time of evaluation, select Yes. If not currently employed, or is retired, select No. If unknown, select UNK.

Must select one:

Yes – The patient is employed (full time or part time) and receiving income at time of evaluation

No – The patient is not employed or is retired.

Unknown

Patient Measurements

Height: Enter the height of the patient in centimeters at time of evaluation. This is a **required** field.

Weight: Enter the weight of the patient in kilograms at time of evaluation. This is a **required** field.

BMI: The patient's BMI will display.

Evaluation Details

Primary Diagnosis: Select the primary diagnosis for the disease requiring a transplant at the time of evaluation for this candidate. If the candidate has had a previous transplant for the same organ type, use Retransplant/Graft Failure as the primary diagnosis for that organ. This is a **required** field.

Must either:

Select value (values TBD) or

Select unknown.

Evaluation Status: Select the evaluation status. This is a **required** field.

Must select one:

Active – The evaluation is in progress.

Closed – The evaluation was closed by the transplant program.

Selection Committee Date: Enter the final selection committee date (MM/DD/YYYY). This is a **required** field.

Selection Committee Decision: Select the decision value (e.g., approved or denied) from the dropdown menu. This is a **required** field.

Must select one:

Approved – The selection committee approved adding the patient to the waiting list.

Denied – The selection committee did not approve of adding the patient to the waiting list.

Selection Committee Decision/Declined Reason: Declined reason for transplantation. Select the declined reason from the dropdown menu. This is a **required** field.

Must select one:

Active infection – Declined due to untreated infection(s) (e.g., HIV, Hepatitis B).

Active mental/behavioral health barriers – Declined due to the presence of untreated or uncontrollable mental health or behavioral health conditions or disorders that interfere with an individual's ability to make an informed healthcare decision, provide informed consent, or adhere to the established care plan; may also include ongoing behavior that prohibits the delivery of appropriate and adequate transplant-related care, including but not limited to, unwillingness or inability to work productively with the transplant care team.

Active/recent malignancy – Declined due to presence of active malignancy or recent (<5 years) high risk malignancy.

Canceled – Canceled by the transplant program due to erroneous submission.

Financial/insurance issues – Declined due to insufficient finances or insurance coverage for transplant due to a variety of reasons including, but not limited to, immigration status and/or homelessness.

Inadequate patient caregiver support – Declined due to insufficient social support for transplantation and related care.

Nutritional/metabolic issues – Declined due to the presence of significantly low/high BMI measurements, frailty, cachexia, malnutrition and/or poorly controlled metabolic syndrome.

Patient age – Declined due to risks associated with advanced age.

Patient choice – Patient requested to discontinue the transplant referral or evaluation for any reason. This includes transition to hospice.

Patient died – Patient died during course of transplant evaluation.

Patient unable to adhere – Declined due to habitual non-attendance to scheduled appointments and/or nonadherence to the treatment plan.

Refusal to accept blood products – Patient refused to receive blood transfusions due to non-medical reasons.

Refusal to vaccinate – Patient refusing to vaccinate according to present CDC recommendations or programmatic policy for non-medical reasons.

Significant cardiovascular disease – Declined due to the presence of severe cardiovascular disease.

Significant hematologic disease – Declined due to the presence of severe hematologic disease.

Significant hepatic disease – Declined due to the presence of severe hepatic disease.

Significant neuro/cognitive disease – Declined due to the presence of severe neuro/cognitive disease.

Significant pulmonary disease – Declined due to the presence of severe pulmonary disease.

Substance use/abuse – Declined due to reported consumption/misuse of substances either on individual occasions or as a regular practice.

Surgical complexity – Declined due to the presence of significant anatomical issues.

Too well for transplant – Patient's illness is not severe enough for transplant surgery. Transplant program advised the patient to pursue chronic disease management services to prevent progression into end-stage organ failure.

Too sick for transplant – Patient's illness is too severe to undergo transplant surgery (e.g., too unstable, on multiple life support systems, or in a coma with evidence of irreversible brain injury).

Transferred to another center – Patient was transferred to another transplant center.

Transplanted at another center – Patient was transplanted at another transplant center.

Unable to contact patient – Unable to contact the patient due to incomplete or inaccurate information.

Death Date: Required if the Declined Reason is Patient Died, Enter the actual or estimated patient date of death (MM/DD/YYYY).

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